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'Prolonged oversight' vowed as congressional panel begins its probe into PSRO program

WASHINGTON, D.C.--Opening a series of congressional hearings on PSROs May 21, Rep. Charles A. Vanik, (D-Ohio), promised "prolonged oversight on this issue" by Congress. Vanik is chairman of an oversight subcommittee of the House Ways and Means Committee.

A major thrust of the first hearing day was cost savings attributable to PSRO review, but Vanik also questioned administration officials on malpractice, bureaucratic delay in promulgating regulations, the status of conditional PSROs and the confidentiality of patient records. Subsequent hearings, one in July and one in the fall, will examine such issues as delegated review and the involvement of other health-care practitioners, such as nurses, optometrists and dentists.

EXPECTATION REASONABLE?

"We would like to discover whether the congressional expectation that PSROs could hold down costs was reasonable, since improved quality of care is often incompatible with lower costs," Vanik said at the outset. "If the congressional goal of holding down costs through PSROs is not reasonable, then we must give renewed attention to finding other types of cost controls."

Louis M. Hellman, M.D., new administra-

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INSIDE STORIES:

PSROs in New York concerned over possible effects of new state law on Medicaid reform

New York's PSROs are aroused by provisions of a new state law on Medicaid that they fear will thrust the state Health Department into medical-care functions regarded as purely PSRO responsibilities.

The law, passed by the state legislature in March and signed by Governor Hugh Carey, calls for a second opinion for elective surgery, a 20-day limitation on inpatient stay, a one-day limitation on preoperative stay, and provides for an on-site monitoring of utilization-review committees by a staff of at least 150, including 20 physicians and 130 nurses, directed by the state health commissioner. A budget of more than $2 million is provided for the 150 jobs.

LITIGATION POSSIBLE

Currently, the PSROs and state and federal health representatives are conducting discussions in an effort to reach agreement on how the new law will be implemented. Although all sides told PSRO Update they wish to reach some agreement, there is a possibility offstage that litigation might eventually pop into the picture. For example, Gov. Carey, in signing the Medicaid bill, warned there were some reform measures that continue to violate federal regulations in a manner that might cause them to be overturned in court.

The bill was aimed at restructuring the state's Medicaid program, and saving $122.5 million in the coming year by freezing (and in some instances, slashing) Medi-

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'Prolonged oversight' vowed as congressional panel begins its probe into PSRO program

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tor of DHEW's Health Services Administration, said that while short-range savings may be achieved by concurrent review, the long-range prospect may be increased costs for individual patients if peer review works as it should. "Do you share the cost-savings concept?" Vanik asked. "That concept is sound to a degree," replied Hellman. "We are going to make more efficient [medical-care] programs, shorten hospital stays and eliminate unnecessary admissions and procedures. However, this may result in putting sicker people into hospitals."

Theodore Cooper, M.D., DHEW assistant secretary for health, told the subcommittee in a separate statement, "It is also possible that costs per individual patient could increase due to less utilization of beds within the hospital and the fact that, as a result of PSRO review, the patients remaining in the hospital will be more seriously ill, requiring more expensive treatments, etc."

Cooper said taxpayers were saved $22.5 million last year as a result of reviews by PSROs in Portland, Ore.; Colorado; Prince George's County, Md.; Montana, Mississippi and Minnesota. For those six conditional PSROs, the average decrease in length of hospital stay during 1975 compared with 1974 was about 6 percent, or half a day, he said. Cooper estimated that full implementation of PSRO hospital review in fiscal year 1980 will cost about $200 million a year. Vanik quoted a Library of Congress study as estimating a fiscal-1977 cost of $69 million to review about 3 million of the 11 million Medicare and Medicaid admissions.

PROGRESS DEFENDED

Vanik asked Department of Health, Education and Welfare representatives why so few PSROs were in business three and a half years after passage of the landmark law. "I think we have proceeded with due and deliberate speed," replied Hellman. "We are introducing into the practice of American medicine something that hasn't existed before and is long overdue. To have proceeded more rapidly would perhaps have been unwise."

Hellman apologized for delay in issuing PSRO regulations but insisted the delay has not hindered implementation of the program. Although it was not discussed at the hearing, the subcommittee had received from DHEW a tentative timetable for publication beginning this summer of proposed regulations on eight aspects of PSRO operations (see separate story).

Vanik also asked Cooper, in a series of written questions, whether PSRO was expected to coordinate Medicare and Medicaid. "PSROs do not coordinate Medicare and Medicaid, but rather provide critical review services to Medicare and Medicaid," Cooper replied. HEW's written responses to Vanik's 30 questions of March 3 generally were not discussed at the May 21 hearing.

EVALUATION BEGUN

Cooper also disclosed that DHEW has begun a PSRO evaluation that will focus first on concurrent hospital review, the impact of medical-care evaluation studies and assessment of the impact of PSRO review on health-care spending.

In preparing for the hearings, Vanik's subcommittee queried PSROs on their evaluation of the program, their relationships with DHEW's Bureau of Quality Assurance, DHEW administration of the program, and PSRO reactions to congressional oversight hearings. Generally, the PSRO responses were skittish and tentative, according to one staff member. Officials of PSROs were reluctant to criticize DHEW administration of the program to a congressional panel and were opposed generally to the hearings. Some complained of being choked by paperwork and criticized the frequent transmittals. Others said DHEW didn't have adequate manpower or financing to effectively administer the program.■

PSROs in New York concerned over possible effects of new state law on Medicaid reform

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caid reimbursement rates for hospitals and nursing homes.

At the time bills were introduced in each house by Assemblyman Alan G. Hevesi, Democrat, of Queens, and state Senator Tarky J. Lombardi, Jr., Republican-Conservative, of Syracuse, they were fought vigorously by the PSROs. Before Gov. Carey signed the final bill, for example, the Kings County Review Organization's board of directors sent a protest telegram to Carey urging him to veto the bill.

The telegram said, in part, "The expenditure of state funds for activities which clearly duplicate those mandated through our PSROs and which are funded from fed-

eral sources is unjustifiable."

Comment from several PSROs indicated how disturbed the PSROs are over the bill's provisions. John Podesta, Kings County executive director, whose PSRO covers 32 hospitals, declared, "We're federally funded, and we are prepared to do the job. To spend additional state monies appears to be duplicative and will cause added burdens to the hospitals, which are also faced with a monetary crisis."

LIMITATIONS QUESTIONED

Lewis Braun of the PSRO state support center pointed out that the new law says the state health commissioner is responsible for establishing standards and norms on such key matters as necessity of admission, controlling length of stay, provision of surgery and other services. He questioned, for example, the provision of a 20-day limitation on inpatient stay. "What if the PSRO determines that length of stay is six weeks--in a burn case, for example?" he asked. On the one-day limitation on preoperative stay he observed, "There are some patients who might require more than a one-day workup."

Braun also noted that the on-site provision--placing a special staff of nurses in hospitals that have 2,000 or more Medicaid discharges a year--collides with PSRO duties. "They will be making determinations, according to a state department official, for necessity of admission and for concurrent and continued stay, and therefore they will be involved in making the determinations for payment," he pointed out. "What we're saying is that this is the responsibility of the PSRO."

Braun noted that at a May 10 meeting at which the PSROs and state and federal representatives discussed the new law, Michael J. Goran, M.D., director of the Bureau of Quality Assurance, DHEW, indicated that, according to federal statutes, the state has the right to monitor the PSROs during the conditional stages, to be sure "they're doing the job properly." Goran added that if the state discovers during monitoring that a PSRO is not doing the job properly, the state can resort to the DHEW Secretary, and DHEW can then stop the PSRO from doing review.

"Goran is saying that the state has the right to monitor, but that PSRO has the right to make decisions on payment," Braun continued. "If the state steps into this, it usurps the role of the PSRO, and it would be in violation of Title 11. The PSROs are willing to work with the state and the feds, but that involves a meeting of minds on what the areas of agreement should be. We are trying to come to some agreement on implementation of these regulations." (The regulations are supposed to be operative by July 1.)

STATE POSITION CITED

State Deputy Health Commissioner Roger Herdman, M.D., told PSRO Update that the state position, as expressed at the May 10 meeting, was that under the new statute, "we had a clear-cut responsibility to implement the new statute as written and as intended." He added, "We have the responsibility to save money because the state budget is balanced on the basis of savings to be realized as a result of the new program.

"On the other hand, it was clear that there were functions" in the statute that might "appropriately be done by the PSROs," Herdman said.

Herdman said that at the May 10 meeting, "We went through the potential areas where PSROs might play a very active cooperative role with us--for example, in the second opinion for elective surgery, in the decisions on whether or not more than one preoperative day for elective surgery would be allowed, and in the decisions as to whether there was a need for a stay for Medicaid patients of more than 20 days."

Herdman pointed out that there would "obviously be a potential for some interrelationship of the state nurses and physicians with PSRO personnel in hospitals." He added, "We suggested that the state people have a program to implement, but we were anxious not to have duplicative work on the part of our people and the PSRO."

NO MANIPULATION ATTEMPTED

Herdman said, "We will attempt to have the PSROs do those parts of the program which they are uniquely suited to do in a cooperative venture with us. In the meantime, they will continue to do their own thing under the federal guidelines, and there is no attempt on the state's part to manipulate that or change that situation at all."

F. Lawrence Clare, M.D., chief of the Professional Standards Review Branch of Region 2,DHEW, noted that the federal position is that the PSROs should determine the criteria by which necessity exists or doesn't exist in the provisions mentioned in the new state law, such as days of preoperative stay, or extension in stay beyond 20 days.

"Policy is evolving in response to the situation," Clare remarked. ■

Time is now to consider PSRO-HSA interactions, health-policy report warns

The University of California Health Policy Program has introduced a plan of possible cooperation between PSROs and HSAs and delineated the steps needed to achieve a harmonious relationship. The plan, based on the first year of a two-year study, was presented in an interim report to the National PSR Council at its meeting May 3 and 4.

'WHAT WILL THE SUM BE?'

"Because the collective impact of both (programs) on medical care may well differ depending on their relationship with each other, the potential HSA-PSRO interactions are worth considering now," the report says. "Government intervention in the medical-care system will escalate so markedly under the two new systems, each being created without much thought to the other, that it is critical to ask as soon as possible what the sum of the two may be."

The report warns of the dangers of meddling by two agencies in each other's operations, but mentions some instances in which interaction could be "desirable and workable." Recommended occasions for cooperation include:

--1. Coordinating PSRO and HSA data to prevent decisions on facilities or procedures by either group that would jeopardize plans of the other.

--2. Opening PSRO aggregate institutional data to HSAs for use in the latter's decision-making processes involving needs for hospital facilities and nursing homes, and setting standards for these institutions.

--3. Solicitation of professional input from physicians on criteria and priorities for HSA activities.

--4. Monitoring and evaluating the impact of HSA activities through PSRO data collection.

FROM PSRO TO HSA

The California group's observations indicate that the greater transfer of resources would flow from PSROs to HSAs. The report also suggests that coordinated efforts could increase the influence of both organizations on providers.

The report recognizes the difficulties inherent in making PSRO data available to HSAs without violating confidentiality. Researchers found physicians reluctant to let data out of the PSRO system and speculated that they might refuse to generate for outside use data that could indicate inadequacies at their institutions.

Aimed at developing a "composite reality" of the HSA-PSRO relationship of the future, the study analyzed well-developed planning and peer-review agencies in four locations: Portland, Ore.; Sacramento, Calif.; Minneapolis, Minn.; and a group of counties in the San Francisco bay area.

Copies of the report will be circulated to at least 10 HSA and PSRO agencies this spring for comment. The Health Policy Program will prepare a final report for DHEW after analyzing additional agencies.■

Liaison network to bring ideas of nonphysician groups before National PSR Council

Nonphysician health professionals will have their views brought directly to the National PSR Council through a "liaison network" approved at last month's meeting of the Council.

The action followed the recommendation of Bureau of Quality Assurance staff that a person designated by the participating groups be allowed to present the views of these nonphysician health professionals at the Council meetings. BQA would distribute information from the Council to these groups.

JANUARY PROPOSAL

The liaison-network plan grew out of a proposal brought to the Council in January by Patricia Ostrow of the American Occupational Therapy Association, to establish a formal advisory committee to the National Council. At that time, endorsement for the idea came from 14 national associations representing nurses, physical therapists, social workers, pharmacists, podiatrists, optometrists, dentists, oral surgeons, medical technologists, bioanalysts, dieticians and others.

Staff of BQA, under the direction of Geraldine Ellis, are now working on details of the scheme and obtaining commitments to participate from nonphysician health professionals.■

PSRO buck will stop closer to home; DHEW regions pick up day-to-day operations responsibility

PSROs, which are accustomed to taking their complaints directly to the central office of the Bureau of Quality Assurance in Washington, will be directing their concerns closer to home in the coming months--to project officers in the DHEW regional offices.

A recent decision by Assistant Secre-

tary for Health Theodore Cooper, M.D., will allow the PSRO program to be decentralized to regional offices for routine operations.

END OF JUNE TARGET

This development, long in coming, was announced at the May meeting of the National PSR Council by Michael J. Goran, M.D., director of the Bureau of Quality Assurance, who noted that most of the project officers in the regions will pick up responsibility for day-to-day operation by the end of June.

However, decisions on contracts, the scope of a PSRO's work, and budgets will still be made at the BQA central offices.

The decentralization, Goran notes, will allow central-office staff to focus on evaluation of PSROs.■

New timetable arranged for publication of key proposed PSRO regulations

For those who follow the often-crucial federal rulemaking process as it affects the development of PSROs, the coming months may offer a number of important publications. The latest timetable, which shows a "slippage" of approximately six months from the previous schedule, comes from the office of the Assistant Secretary for Health and lists the months in which the government expects to publish notices of proposed rulemaking:

June--assumption of review authority by conditional PSROs;
--advisory groups to PSROs (final regs);
--advisory groups to statewide councils;
--statewide councils;
July--hospital-review requirements;
--reconsiderations and appeals;
August--confidentiality;
September--funding agreements;
October--sanctions.

Three areas of the PSRO program have had final regulations published: area designations, in March, 1974; notification and polling procedures, in May, 1974; and interim hearings and appeals, in February, 1976. In addition, notices of proposed rulemaking have appeared for advisory groups, in May, 1975, and for statewide polls, in April, 1976.■

National Council backs request of Samoa and Micronesia medical officers for PSRO entry

Medical officers of American Samoa and Micronesia, who are seeking admission to the Pacific PSRO, found their cause advanced at the May meeting of the National PSR Council, which agreed to support a technical amendment to the PSRO law to permit M.O. membership.

M.O.s receive four to five years of special post-secondary-school medical training and are licensed by American Samoa and the Trust Territory of the Pacific Islands (Micronesia) to practice medicine and surgery there; currently 55 M.O.s are in practice.

AMENDMENT NEEDED

Requests for M.O. membership in PSRO have come from the Pacific PSRO (Hawaii, Guam, American Samoa and the Trust Territory) and the governor of American Samoa. To open the PSRO to M.O.s would require a technical amendment, the introduction of which is under consideration by DHEW.

Comments from the Council showed that physicians are wary about opening the PSRO membership to nonphysicians. However, members' approval of the M.O. request seemed to hinge, in the end, on specifics of their particular case: the M.O.s' licensure by the territories, their tradition of practicing medicine in those areas, and a strong endorsement of the move by the Pacific PSRO.

But, on another tack, Council member Raymond J. Saloom, D.O., shaking his head and evidently seeing the Pacific as a long way from Washington, said, "I have a friend who left for American Samoa because he wanted to stay out of PSROs and HSAs."■

National Council members indicate they are not ready to open doors to dentists

PSRO membership for dentists is apparently unlikely for a while, if the current sentiment of the National PSR Council continues.

LITTLE DISCUSSION

At the May 3-4 Council meeting, members' opinions on the inclusion of dentists were sought by William B. Munier, M.D., acting director of the Office of Quality Standards, who asked the question on behalf of the Assistant Secretary for Health. With little discussion, members indicated they were not yet ready to open the door of PSRO membership to dentists.

However, the question was inserted into the agenda at the end of a full-day session, and followed immediately a discussion that concluded with the Council supporting the request of medical officers (nonphysicians) in American Samoa and Micronesia to be included in PSRO membership (see separate story). Council members appeared unwilling at the time to tackle the larger question of opening up PSRO membership to other nonphysi-

cians. Thus, the timing of the question on the agenda may have had an effect on the answer.

SOME HAVE DENTISTS

Some PSROs have dentists on their board of directors even though, by law, PSROs bar membership by dentists.

Comments from a spokesperson for the American Dental Association at the end of the meeting indicated that dentists reject being grouped with nonphysician health professionals in a "liaison" relationship with the Council (see separate story), preferring instead to hold out for membership on the councils and in the PSROs.■

Goran gives status report; notes rise in admission review, signing of MOUs by 47 PSROs

Twenty-eight new conditional PSROs are expected to have contracts from DHEW by the end of June, and the 65 current conditionals anticipate renewals of their contracts by that time, according to Michael J. Goran, M.D., director of the Bureau of Quality Assurance.

Conditional PSROs were reviewing, at an annual rate, 700,000 admissions on federally paid patients by the end of March, Goran reported; the number was expected to be 1.25 million admissions by the end of June. This means that in those areas in which review is under way, 35 percent of the patient admissions will be undergoing review by the end of this month.

SOME BARRIERS DOWN

These figures were part of a status report presented to the National PSR Council at its May 3-4 meeting. Goran noted that memoranda of understanding, which had been one of the major barriers, have been completed by 47 PSROs and Medicaid authorities, although, he said, "Medicaid review is still the barrier in California, Michigan, Missouri and Wisconsin." The situation created in New York by a new state law (see separate story) has tremendously complicated the picture there, he indicated.

The next major undertaking for a PSRO, once it has started review in acute-care hospitals, is review in long-term-care facilities. Under the law, a PSRO must do long-term-care review before it can become operational. Funding may become a problem, Goran said, because "long-term care did not get the funds that the new amendment gave acute care, and so it will have to be financed by direct funding."

DEMONSTRATIONS DUE

PSROs will be encouraged to implement long-term-care review, the director said, as long as it doesn't interfere with acute-care review. BQA intends to fund up to 10 demonstration projects, for which it is soliciting proposals from PSROs.

Ambulatory-care review will also be the subject of study at 10 demonstration sites, for which proposals are being solicited early this month, Goran said. He noted that, fortunately, "for ambulatory-care review, we'll have more time to look at what's happening." ■

BQA tries to improve the 'fit' between PSRO and FI on factors in payment decision

PSROs are currently reviewing a Bureau of Quality Assurance draft transmittal on "level of care" aimed at improving the "fit" between the fiscal intermediary and the PSRO.

The decision on whether a Medicare or Medicaid patient's hospital care is to be paid depends on several factors, only two of which are PSRO responsibilities: medical necessity and appropriate level of care. The other responsibilities--a patient's eligibility, the extent of coverage of the program and the reimbursement policies of the fiscal intermediaries--are up to Medicare and Medicaid.

DECISION-PAYMENT LINK

To provide links between PSRO decisions and payment policies of Medicare and Medicaid, the BQA has tackled the subject in what is called a level-of-care transmittal, presented to the National PSR Council in May.

The proposed policy contained in the transmittal encourages the PSRO to be well aware of the guidelines on which decisions about payment are made by Medicare and Medicaid, although the principle of separate responsibilities should be maintained, it stresses.

At best, the transmittal notes, "PSROs could directly apply payment program coverage guidelines...at the time of concurrent review."

However, several Council members questioned the appropriateness of physicians and coordinators even knowing the payment policies of the intermediaries, for fear their medical decisions might be influenced by conditions of payment.

THE LESS KNOWN, THE BETTER

Council member Merlin K. DuVal, M.D., said, "I believe the less the PSRO knows about payment policies, the better it will do its job." Similarly, Alan R. Nelson, M.D., noted, "The PSRO has to be the patient's

advocate in respect to the fiscal intermediary."

On the other hand, the comment from Cornelius L. Hopper, M.D., took the opposite approach: "If you think that, if I am a physician on a review committee, my decision will not consider the effect on the hospital, you're functioning in an unreal world. I would want to know what the guidelines are."

Along the same line, Ruth M. Covell, M.D., said, "Reimbursement decisions will be made regardless of whether the physician knows what the policy is."

WHAT IT SAID

In clarifying the policy, the BQA's James Roberts, M.D., said, "The transmittal attempted to say, first, that regarding coverage of particular services--for example, scans--the PSRO should make determinations regarding medical necessity; the payment mechanism may then say, 'OK, but we don't cover it.' And, second, that regarding definitions of levels of care, the PSRO should use definitions of Medicare and Medicaid, so that their decisions will be binding for payment."

The 23-page draft transmittal also provides four appendices containing a number of Medicare definitions and examples, as well as an interim policy statement concerning payment after an adverse determination by a PSRO.■

How one state tries to deal with the problem of mentally or physically impaired physicians

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also said a physician could appeal this action and that during the appeal process, he could continue to practice.

Over a two-year period, a committee of the medical society drafted recommendations for a new law, which were accepted by the state legislators with very few changes. First, the responsibility for disciplining physicians was removed from the Board of Medical Examiners to a separate commission of nine physicians, including the president and chairman of the council of the state medical society. The commission can subpoena and make the physician liable to prosecution if he perjures himself, and all proceedings before the board are part of the public record. The law also says that the commission must refer any cases coming to its attention to the appropriate local county medical society or committee of the state medical society for their investigation and report. It also says that the medical society may initiate action on its own and may call on the commission to subpoena on its behalf or become involved in any case at any time.

CAN REQUIRE EXAMS

Q. Does the law specifically mention impairment?

A. Yes, one provision calls for revocation, or suspension of license, or probation or reprimand for "professional, physical or mental incompetency." Amendments to the act also provide that a doctor can be required to undergo mental or physical examinations and that, if found guilty by the commission, he cannot practice while appeals are under way.

Q. What has been the effect of this law on practice in Maryland?

A. This is one time when the medical profession can be proud of its peer-review job. While our emphasis is not on revoking licences, it is on protecting patients and helping physicians get help. In dealing with senile, alcoholic, drug-dependent or otherwise ill physicians, the medical society now has real leverage

PROTECTION A MAJOR PROBLEM

Q. Are all the problems ironed out with respect to tough discipline?

A. Not by a long shot. For example, we are still working on the major problem of protecting a physician who appears before a medical society committee from losing his rights and from the threat of legal action from those he may testify against.

Q. Do PSROs have any role in working with the state commission?

A. There's no mention of PSRO in the law dealing with the commission. The PSRO could use the commission or the medical society as any third party could, asking for an investigation of a problem that they submit, but there's no mechanism that I'm aware of that would go the other way--where the commission would go to the PSRO and say, Would you investigate something for us?

Q. Do you feel Maryland has come a long way in dealing with this problem?

A. Absolutely. No medical society could ask for such a law unless its membership is willing first to admit that we have a serious problem with some of our associates, and, second, that sometimes we will have to ask that a colleague be denied the right to practice medicine. Our statute, with all its problems, has provided organized medicine here with the opportunity to police itself and to meaningfully assure the public that only competent physicians may practice in the state. And that is what peer review is all about.■

How one state tries to deal with the problem of mentally or physically impaired physicians

PSRO Update this month presents an interview with Joseph I. Berman, M.D., an advocate of strong peer review, on methods of dealing with physically or mentally impaired physicians. Berman, chairman of the Department of Community Medicine at Sinai Hospital in Baltimore, Md., heads the Peer Review Committee of the Medical and Chirurgical Faculty of Maryland, the state's medical society.

Q. Many physicians insist that the number of physically and/or mentally impaired physicians practicing in the United States is so small as to be insignificant. Just what is the scope of the problem?

A. It is certainly not insignificant. With respect to physical disabilities, we have no real idea of the size of the problem, but such disabilities are difficult to hide and are usually dealt with more easily. The psychological disorders are the tougher problems, and we are starting to get a picture of how widespread they are. According to information reported at the San Francisco conference on the impaired physician, a conservative estimate would be that approximately 17,000 physicians, or from 5 to 6 percent of all practitioners, are disabled by alcoholism, drug dependence or mental illness.

ALCOHOLISM BIGGEST PROBLEM

Q. Of these three problems, which is the biggest?

A. By far, alcoholism. Some observers believe it is responsible for half the sick-physician pathology. Others say two-thirds. If, again conservatively, we say that only half the impaired physicians are presently active alcoholics with effects that interfere with their medical practice, we get a total of 10,000 physicians.

Q. What have been the traditional mechanisms for dealing with the impaired physician who may be incompetent to treat patients?

A. In the past, most physicians attempted to ignore the problem, or at best, tried in unofficial ways, through spouse or friend, to handle this situation. They may see him drunk, or drinking heavily at parties, and maybe they will carefully suggest that he get some help.

Q. Do they ever suggest that he leave practice?

A. Rarely. For one thing, they believe that a physician, because of his training, is the best one to judge his own medical needs, even though we know that physicians are notoriously bad at this. Also, many physicians take the attitude that 'There, but for the grace of God, go I' and are just as happy to leave the whole thing alone.

Q. I suspect that this informal, unofficial approach is giving way to something stronger.

A. Absolutely. Licensing bodies and state medical societies are getting involved with statutory authority to conduct tough peer review of these impaired physicians. When you have the force of law behind you, it's a whole different ball game.

TWO STATES STAND OUT

Q. Who has such laws?

A. Very few states. But Maryland and Florida have highly developed authority of this kind, and the AMA has written a model law based on the Florida statute, which created a disciplinary body that works totally independently of the state medical society and even has state-paid investigators.

Q. You feel that Maryland's law is unique and possibly more appealing, that is, easier for physicians to work with?

A. It certainly is unique in the sense that the medical society helped to write it and heavily supported it in the legislature. In a survey by the AMA in 1972, 23 out of the 54 medical societies surveyed said they had no program to deal with the sick physician. Three claimed outright there was no problem, and the rest expressed indifference that bordered on a denial of the problem as well.

Maryland does not have a "disabled physician act," per se. Rather, the situation is covered in the law dealing with physician discipline, with peer review, as the result of legislation passed in 1969. That year the Commission on Medical Discipline, a state agency, was established.

Q. The commission has a special relationship with the medical society, doesn't it?

A. Yes. Before 1969, the law stated that the Board of Medical Examiners could revoke or suspend a physician's license, or place him on probation for fraud, drunkenness, insanity, addiction to narcotics, abortion (at that time illegal in Maryland) or conviction of a crime involving moral turpitude or unprofessional conduct. It

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